



# Chugach Chiropractic Clinic LLC

11462 Business Boulevard, Eagle River, Alaska 99577

(907) 694-9224 ♦ Fax: (907) 694-1066

www.careforyourspine.com

## Patient Information

PLEASE PROVIDE A VALID PICTURE ID TO THE FRONT DESK

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

\_\_\_\_\_

LAST NAME: \_\_\_\_\_ SEX: MALE or FEMALE

CITY, STATE, ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ MARITAL STATUS: M S D W

PHYSICAL ADDRESS: \_\_\_\_\_

CIRCLE ONE: EMPLOYED STUDENT

CELL PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

RETIRED UNEMPLOYED

WORK PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMPLOYER/OCCUPATION: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ @ \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE ONE)

IS THIS A WORK RELATED INJURY/AUTO ACCIDENT? YES or NO  
(IF YES, PLEASE SEE THE FRONT DESK)

FACEBOOK LOCATION

ANOTHER PROVIDER WEBSITE

STAFF

WHO? \_\_\_\_\_

EXISTING PATIENT

WHO? \_\_\_\_\_

OTHER (PLEASE SPECIFY): \_\_\_\_\_

## Insurance Information

PLEASE PROVIDE YOUR INSURANCE CARD TO THE FRONT DESK

INSURANCE COMPANY: \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

POLICY HOLDER'S BIRTHDATE: \_\_\_\_\_

POLICY ID NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

## Secondary Insurance Information

INSURANCE COMPANY: \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

POLICY HOLDER'S BIRTHDATE: \_\_\_\_\_

POLICY ID NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

## Emergency Contact

NAME: \_\_\_\_\_ HOME PHONE #: \_\_\_\_\_ CELL/WORK #: \_\_\_\_\_

**Assignment & Release** - By signing below, I authorize Chugach Chiropractic Clinic LLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Chugach Chiropractic Clinic LLC. I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any reasonable collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.

**Consent to Treatment** - By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.